TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JOSEPH MORGAN DPM

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-0178-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted in the dispute packet.

Amount in Dispute: $294.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed for bilateral tendon sheath injections, 20550-50(2). (Attachment) However, the requestor's documentation only indicates injection to the left foot. The documentation contradicts the coding. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2015	CPT Code 20550-RT and 20550-LT Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	$294.00	$89.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16-Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 732-Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
- 876-Required documentation missing or illegible. See rules 133.1; 133.210; 129.5; or 180.22.

Issues

Does the documentation support billing codes 20550-RT and 20550-LT? Is the requestor entitled to reimbursement?

Findings

The respondent initially denied reimbursement for CPT codes 20550-RT and 20550-LT based upon reason codes "CAC-16" and "225."

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

A review of the Operative Report indicates, "Injection to resolve the traumatic plantar fasciitis at insertion of left calcaneous was given today."

The Division finds that the requestor supports billing CPT code 20550-LT but not 20550-RT; therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203(c).

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The requestor indicated the service was performed in the physician's office.

The 2015 DWC conversion factor for this service is 56.2

The Medicare Conversion Factor is 35.7547

Review of Box 32 on the CMS-1500 the services were rendered in zip code 79761, which is located in Odessa, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The Medicare participating amount $57.09.

Using the above formula, the Division finds the MAR is $89.74. The respondent paid $0.00. The difference between the MAR and amount paid is $89.74; this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $89.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $89.74 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/10/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.